

**MEDICAID -
PRIMARY CARE
CASE MANAGEMENT PROGRAM**

Service Chapter 510-06

**North Dakota Department of Human Services
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(Revised 6/1/2010 ML #3219)

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Certain groups within Medicaid are required to enroll in a managed care program. The Primary Care Case Management (PCCM) program is the only Statewide managed care program serving Medicaid recipients. This program requires Medicaid recipients to choose a Primary Care Provider (PCP) to manage their health care needs and provide referrals for specialty services as needed.

The PCCM program is designed to provide the Medicaid recipient with adequate access to primary care, coordination and continuity of health care services and quality care.

County social service agencies provide Medicaid applicants/recipients with written information (*Guide to North Dakota Medicaid's Primary Care Provider Program* handbook) about the managed care programs and inform them of their responsibility to select a PCP in their surrounding area.

Guide to North Dakota Medicaid's Primary Care Provider Program handbook for recipients is located at:

<http://www.nd.gov/dhs/services/medicalserv/medicaid/managedcare.html>

Medicaid Recipients Who Require a PCP 510-06-05
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A PCP must be selected by or on behalf of all members of a medical assistance unit except for the following groups:

- Aged, blind, or disabled individuals
- Individuals with Medicare health insurance coverage
- Residents of the following facilities:
 - Nursing facilities/Long term care,
 - ICF/MR facilities,
 - State Hospital,
 - Institution for Mental Disease (IMD)
- Individuals in receipt of home and community based services (HCBS), Foster Care, Subsidized Adoption, and refugees.
- Individuals eligible for Medicaid through the Women's Way Program.
- A PCP is not required during any of the three months prior to the Medicaid application month.

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Primary Care Provider Selection 510-06-15 **(Revised 6/1/2010 ML #3219)**

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Upon applying for Medicaid, the eligibility worker informs the Medicaid recipient of the requirement to name a PCP. The Medicaid recipient is also mailed the Applicant PCP Inform/Enrollment Notice. This notice is system generated once the application is approved. The recipient has approximately fourteen (14) days from the date the Applicant PCP Inform/Enrollment Notice is mailed in which to select a PCP. The Medicaid recipient may inform the eligibility worker of their PCP selection in the initial Medicaid application, another written form, or verbally.

The recipient may choose a provider in the recipient's county or surrounding area. Assistance may be provided by the eligibility worker in the selection of a PCP. Enrollees should select a PCP that will meet their medical needs. The eligibility worker should not influence the recipient's decision on which primary care provider to select, but should only offer information. A list of providers is available under the Search Primary Care Provider screen within the Vision system.

If a PCP is not chosen within fourteen (14) days of being notified of the PCP requirement (the date of the Applicant PCP Inform/Enrollment Notice is mailed), the recipient will be subject to default enrollment in which the Department will assign a PCP.

Once the PCP is selected and entered into the system, a letter is automatically generated and mailed to the recipient notifying them of the PCP assignment and the rules regarding when and how to request a change or transfer in their PCP selection.

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The following types of Primary Care Providers may be selected:

- Advanced Registered Nurse Practitioners
- Family/General Practitioners
- Internists
- Pediatricians
- Obstetricians/Gynecologists
- Rural Health Clinics (RHC)
- Federally Qualified Health Clinics (FQHC)
- Indian Health Services (IHS) within the State

Once a PCP is identified and entered into the system (whether it was a selection from the recipient or through the default enrollment process), the Managed Care Benefit Plan requirements pertain to their medical care. Changing the dates of the PCP at the request of medical facilities to allow for billing and payment of claims is unacceptable. Should a medical facility have questions regarding billing they may be directed to contact Provider Relations.

Claims are not subject to PCCM requirements until the PCP is assigned and entered by the County Agency or through the default enrollment process.

At the time a case closes or a recipient loses Medicaid eligibility, the PCP for that recipient ends. If the case reopens within the same month, the PCP continues.

When a case is closed for more than 30 days, the recipient must be re-informed of the PCP requirements.

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Referral Requirements Within the PCCM Program 510-06-17

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The PCP must generate referrals for specialty care to be received by the recipient.

Recipients are allowed to seek emergency services for valid emergency medical conditions from any medical facility without a referral from the PCP. However, if possible the recipient should provide the medical facility with the name of their PCP. Any follow up care and/or treatment not provided or performed by the recipient's PCP requires a referral.

If the recipient's PCP is not available, the recipient may see a colleague of their PCP without a referral. The colleague must be within the same facility and be of a specialty that may serve as a PCP.

Same facility is defined as a facility that is associated with the Primary Care Provider's facility by having the same Medicaid Provider Identification number as the PCP's facility when submitting a claim.

Further referral requirements can be located within the recipient *PCCM Program Handbook* or the *General Information for Providers Manual*, Managed Care Chapter.

Change in PCP/Open Enrollment 510-06-20

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Recipients may request a change in their PCP every six months or if they have good cause. When a good cause request is made to change the PCP, the eligibility worker needs to determine if good cause exists and document the reason and decision. The eligibility worker determines the appropriate good cause change reason to use. Notification of denial of good cause must be provided to the recipient. This can be completed by using the Change in Primary Care Provider-Denied form.

Recipients may request a change of their PCP without good cause within 90 days of each selection of a PCP. Once 90 days has passed with no change in PCP, the recipient must remain with that PCP for six (6) months unless they have good cause to require a change.

Good cause for changing a PCP within the six months selection period exists if:

- Recipient Relocated (RR)
- Significant changes in the recipient's health require the selection of a PCP with a different specialty (Health status (HS))
- PCP relocated (PR)
- PCP refuses to act as a PCP or refuses to continue to act as a PCP (RE)
- Redetermination of Medicaid (RD)
- No longer an enrolled Medicaid provider (NP)
- Agency discretion (AG)

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Additional Reasons include:

- Pended PCP selection (PE)
- Exempt from requirement (EX)

Exemptions:

A recipient is **temporarily exempt** from selecting a PCP **only if they are not able to find a provider who will agree to be designated as their PCP**. Claims are not subject to referral requirements during an exempt period.

Newborns are allowed a seven (7) day exemption prior to the PCP effective date. The exempt period count starts the day after the birth date.

For Example: If the birth date is January 1st, and the eligibility worker enters January 1st as the inform date; the system will build an Exempt period of January 1st to January 8th and the PCP effective date (PCP start date) will default to January 9th. Another example would be if the birth date is January 1st and the inform date entered is January 5th, the exempt period would be January 5th through January 8th and the PCP effective date would be January 9th.

If a recipient becomes exempt from the PCP requirements (i.e. enter foster care), they are exempt effective the date of that change.

Open Enrollment:

Recipients are offered an Open Enrollment period every six (6) months which allows them to select a new PCP. An Open Enrollment notice is sent to the recipient sixty (60) days prior to the Open Enrollment End Dates. This date is located on the *Assign Primary Care Provider Window* within the Vision system.

Should the recipient choose to change providers during this Open Enrollment period, the Open Enrollment change reason code (OE)

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must be utilized. This does NOT take effect immediately upon entering the new provider. The effective date of the new provider will be the first of the month following the open enrollment end date.

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PCP and Coordinated Services Program (CSP) 510-06-25

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Under the Coordinated Services Program (CSP), a review is completed by the Surveillance Utilization Review System (SURS) staff within the Medical Services Division. This review will assist to determine if certain recipients are misutilizing services. When this review is completed, and it is determined that a recipient is misutilizing, the SURS staff contacts the county agency and asks that the recipient choose a provider who will be asked to manage the recipient's health care. The eligibility worker will review the guidelines and policy for the CSP Program with the recipient.

The Coordinated Services Program is more stringent in looking at the recipient's medical needs and in establishing controls to assure that the recipient receives continuity of care while learning acceptable utilization practices. In addition, the recipient may be locked into certain providers who are exempt from PCP, such as psychiatrists, dentists, and pharmacies.

If a coordinated services recipient is required to name a PCP, that provider must be the same as the Coordinated Services Program provider. If the Coordinated Services Provider is one that is not on the Primary Care Provider list, please contact the SURS administrator. The PCP will then be changed to an "exempt" status. However, this does not exempt the recipient from any referral requirements. The recipient will be required to follow the rules outlined within the Coordinated Services Program. All CSP rules supersede the PCCM guidelines.

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Recipients on the Coordinated Services Program will remain on it until their status has been changed by recommendation of the department's professional consultants.

The rules for changing a PCP in Coordinated Services Program cases must follow the Coordinated Services Program policy and must be approved by SURS staff. These rules can be located within the *General Information for Providers* Manual, Coordinated Services Chapter which can be located electronically at:
<http://www.nd.gov/dhs/services/medicalserv/medicaid/docs/gen-info-providers.pdf>